

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Example 7a
Deductible,
Coinsurance,
and Other TPL

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Form with 33 numbered sections. Includes fields for patient name (Doe, Jane), address, birth date, insurance type (Medicare/Medicaid), provider name (Seuss, Theodor MD), charges (\$180.00), and signature (Jim Livingston, MD).

1

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6

7

MEDICARE SERVICE CENTER
901 40TH STREET S, SUITE 1
FARGO, ND 581032146

8

*Note: Your EOMB may be
formatted differently.*

*Example 7b
Deductible,
Coinsurance,
and Other TPL*

MEDICARE
REMITTANCE
NOTICE

ABC MEDICAL GROUP
PO BOX 4444
ANCHORAGE, AK 99501-1000

PROVIDER #: K0000BHXBK
DATE: 4/04/10
CHECK/EFT #: 183699999
PAGE #: 1

REND PROV	SERVICE DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME LIVINGSTON, JIM		HIC 987654321A	ACNT 11434-099999			ICN 1111987654321	ASG Y	MOA MA01 MA15		
1711111111 0320 032010		11 1	J1480		180.00	77.20	70.00	1.44	102.80	5.76
PT RESP 71.44			CLAIM TOTALS		180.00	77.20	70.00	1.44	102.80	5.76
ADJ TO TOTALS: PREV PD			INTEREST		0.00	LATE FILING CHARGE	0.00		NET	0.00
CLAIM INFORMATION FORWARDED TO: STATE OF ALASKA MEDICAID PROGRAM										

9

Note: Your EOMB may be formatted differently.

*Example 7c
Deductible,
Coinsurance,
and Other TPL*



P.O. Box 240489
Anchorage, AK 99524

Page C-20
Date of Payment: APRIL 6, 2008
Check Number: 0987654321
Payment Reference #: 1234567890123456
Provider Number: 200098765432
Provider Tax ID Number: 123123123
NPI ID: 1212121212

ABC MEDICAL GROUP
PO Box 4444
Anchorage, AK 99501-1000

**APRIL 6, 2010
DETAILED EXPLANATION OF PAYMENT**

Patient Name Subscriber # & PT Suffix Patient Account # Subscriber Name Claim # Provider of Service Product	SERVICE DATES	CODE/ MODIFIER	UNITS BILLED/ ALLOWED	APC/ APG/ DRG/ ROOM TYPE	BILLED CHARGES	INFORMATIONAL	PROVIDER	OTHER INSURANCE ADJUSTMENT	PATIENT LIABILITY	PAYABLE AMOUNT	REASON REMARKS
						AMOUNT ALLOWED	ADJUSTMENT (A) DISALLOWED (D)		FEE ADJUST (A) COB SAV APP (B) COINSURANCE (C) DEDUCTIBLE (D) FUNDING ACCT (F) INELIGIBLE (I) COPAY (P)		
DOE, JANE 1234567890 0812345 DOE, JANE 312894723498 ABC MEDICAL GROUP	032010 032010	J1480	1 / 1		71.44	71.44		0.00	0.00	36.00	
	Claim Total		Paid To: G		\$71.44	\$71.44	\$0.00	\$0.00	\$0.00	\$36.00	

Our records indicate your current TAX ID as being 920009999

Reason Remarks Explanation

- E CONDITION ONSET DATE NEEDED BEFORE CLAIM CAN BE PROCESSED.
- X THE COORDINATION OF BENEFITS INFORMATION RECEIVED IS INCOMPLETE. OTHER CARRIER PAYMENT INFORMATION IS NEEDED BEFORE CLAIM CAN BE PROCESSED.
- O BENEFITS NOT PROVIDED BECAUSE A MEDICAL PREMISES POLICY IS RESPONSIBLE. CONTACT CUSTOMER SVC IF BENEFITS ARE DENIED/EXHAUSTED.
- P THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY SUBMITTED CLAIM FOR THIS MEMBER.
- S A DISCOUNT WAS APPLIED TO THIS CLAIM.
- T THE MEMBER'S OUT OF POCKET MAXIMUM WAS MET.
- B THE MEMBER'S COVERAGE WASN'T IN EFFECT ON THE DATE SERVICES WERE PROVIDED.
- M AMOUNT WHICH REIMBURSEMENT TO PROVIDER IS LESS THAN THE AMOUNT OF BILLED CHARGES.

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Medicaid
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**Example 8a
Coinsurance
Only**

CARRIER

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input checked="" type="checkbox"/> (Medicare #) MEDICAID <input checked="" type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/> MM DD YY M F	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Jane		10. IS PATIENT'S CONDITION RELATED TO: 2	
a. OTHER INSURED'S POLICY OR GROUP NUMBER 987654321A		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input checked="" type="checkbox"/> 01 01 34 M F		b. AUTO ACCIDENT? (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME Retired		c. OTHER ACCIDENT? (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME Medicare		10d. RESERVED FOR LOCAL USE 04/04/10	
11. INSURED'S POLICY GROUP OR FECA NUMBER Medicare			
a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>		b. EMPLOYER'S NAME OR SCHOOL NAME Retired	
c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Signature on File SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature on File SIGNED	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF PROVIDER OR OTHER SOURCE 4 Seuss, [Redacted] MD.		17a. ID MD1234 17b. NPI 1231231231	
19. RESERVED FOR LOCAL USE A2 15.44		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 123 04		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
1 03 20 10 03 20 10 11 99213		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
		23. PRIOR AUTHORIZATION NUMBER	
		24. F. \$ CHARGES 77.20 180.00 G. DAYS OR UNITS LTC 1 H. EPSOT Family Plan N I. ID. QUAL. ZZ J. RENDERING PROVIDER ID. # 123D00000X 1234567890	
		25. FEDERAL TAX I.D. NUMBER SSN EIN	
		26. PATIENT'S ACCOUNT NO.	
		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
		28. TOTAL CHARGE \$ 180.00 29. AMOUNT PAID \$ 61.75 30. BALANCE DUE \$ 118.25	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jim Livingston, MD <i>Jim Livingston, MD 4/07/10</i>		32. SERVICE FACILITY LOCATION INFORMATION ABC General Practice 1000 Main St Anchorage, AK 99507-1234	
		33. BILLING PROVIDER INFO & PH # (907) 277-0000 ABC Medical Group PO Box 4444 Anchorage, AK 99501-1000	
a. NPI		a. 3333333333 b. ZZ193400000X	

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PHYSICIAN OR SUPPLIER INFORMATION

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*Example 8b
Coinsurance
Only*

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1711111111 0320 032010		11 1	99213		180.00	77.20	0.00	15.44 102.80		61.75
PT RESP 15.44			CLAIM TOTALS		180.00	77.20	0.00	15.44 102.80		61.75
ADJ TO TOTALS: PREV PD			INTEREST		0.00	LATE FILING CHARGE	0.00	NET		61.75
CLAIM INFORMATION FORWARDED TO: STATE OF ALASKA MEDICAID PROGRAM										

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY N... UNIFORM CLAIM COMMITTEE 08/05

Medicaid
PO Box 240769
Anchorage, AK 99524-0769

Example 9a
Deductible Only

CARRIER

Main form body containing sections 1-33 with various fields for patient information, insurance details, and provider information. Includes handwritten annotations like '1', '2', '3', '4', '5', '6', '7' and circled values.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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Example 9b
Deductible Only

MEDICARE
REMITTANCE
NOTICE

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1711111111 0320 032010		11 1	99213		180.00	77.20	77.20	0.00	102.80	0.00
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CLAIM INFORMATION FORWARDED TO: STATE OF ALASKA MEDICAID PROGRAM										

Completing the CMS-1500 Claim Form for Professional Medicare Crossover Paper Claims

Providers should complete the CMS-1500 for Medicare crossover paper claims as they would for non-crossover paper claims billing for Medicare. All required fields found in non-crossover claims are also required on crossover claims. Additional requirements for the Medicare crossover components of these claims are listed below.

Rule: Only one service line per document is permitted.

Additional requirements for Professional Crossover claims:

1.	Field 1:	Check both the Medicare and Medicaid box.
2.	Field 10d: <i>RESERVED FOR LOCAL USE</i>	Enter the Medicare pay date using the mm/dd/yy format.
3.	Field 11: <i>INSURED'S POLICY GROUP OR FECA NUMBER</i>	Enter the word "MEDICARE".
4.	Field 19: <i>RESERVED FOR LOCAL USE</i>	Enter the deductible amount using qualifier A1 and the coinsurance amounts using qualifier A2; use a space between the qualifier and the amount (e.g., A1 70.00 A2 1.44). If there was a third-party payment from a source other than Medicare, enter this amount using qualifier TP; use a space between the qualifier and the amount (e.g., A1 70.00 A2 1.44 TP 36.00).

Field 24, shaded part of line 1 (only one service, on one line, per claim form) contains:

5.	24f, shaded area: \$ <i>CHARGES</i>	Enter the Medicare allowed amount. Be sure to enter the decimal point.
6.	Field 28: <i>TOTAL CHARGE</i>	Enter the Medicare billed amount.
7.	Field 29: <i>AMOUNT PAID</i>	Enter the Medicare paid amount.
8.	The EOMB	A copy of the Medicare EOMB must be attached to the claim.
9.	The TPL EOMB	If there was a third-party payment from a source other than Medicare, a copy of the third-party EOMB must be attached to the claim.

For more information on completing the CMS-1500, download the appropriate claim form instructions at: <http://medicaidalaska.com/providers/provupdates.shtml>.